MEDRx

3250 W. Pleasant Run, Suite 125 Lancaster, TX 75146-1069
Ph 972-825-7231 Fax 972-274-9022

Notice of Independent Review Decision

DATE OF REVIEW: 8/29/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity Physical Therapy 24 sessions (lumbar spine).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Doctor of Chiropractic who is board certified in Chiropractic.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Upheld (Agree)
☐ Overturned (Disagree)
☒ Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity Physical Therapy 16 sessions (lumbar spine).

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity Physical Therapy 8 sessions (lumbar spine).

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
Insurance Co. of the State of PA & Cynthia Airhart, D.C., CCEP

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from Insurance Co of the State of PA

Progress Evaluation- 4/2/12
MRI Lumbar Spine w/o Contrast- 8/11/11
. Left Transforaminal Epidural Steroid Injections- 11/29/11
Office Notes- 12/27/11
Follow-Up Evaluation- 1/30/12
Initial Evaluation- 10/4/11

Progress Notes- 4/30/12, 6/24/11
Re-Examination Notes- 7/13/12
Physical Therapy Request- 6/1/12

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, the patient was injured. The date of injury is over xx and he recently had surgery four months ago. The report states the patient was at work and twisted his back while falling. After the accident he received a course of conservative care that included multiple sessions of physical therapy and Lumbar Epidural Steroid injection. On April 30, 2012 he underwent bilateral hemilaminotomies with medial facetectomies and bilateral foraminotomies. Additionally, L4-5 and L5-S1 diskectomies were performed on this date.

CT myelogram of his lumbar spine revealed at L5-S1 a 6 mm protrusion lateralizing to the foraminal and extra foraminal regions worse on the left than right. Moderate foraminal stenosis with mass effect on the L5 ganglia worse on the left. At L4-L5 there is a disc protrusion of 5 mm with marked right and left ligamentous hypertrophy with lateral recess stenosis at the L5 nerve roots. The MRI studies revealed left sided L5-S1 foraminal stenosis and L5-S1 disc bulge of 2 mm that could result in L5 radiculopathy.

Electrodiagnostic studies revealed left sided L5 radiculopathy on 10/04/2011. MD recommended the patient undergo 4 weeks of therapy to improve function and mobility for three times a week. Chiropractic has suggested three visits per week for 60 days

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Recommend partial approval of requested services. According to the ODG criteria for admission to a Post-Surgical rehab there is evidence of faster decrease in pain and disability when these programs are started 4-6 weeks post-surgical intervention. The documentation on the above patient validates the medical necessity of 16 of the requested sessions according to ODG Physical Therapy Guidelines on Post-Surgical therapy treatment in the lumbar spine. The additional 8 sessions of the requested program are found to be not medically necessary at this time based upon the ODG.

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):
Medical treatment: 10 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks
Post-surgical treatment (arthroplasty): 26 visits over 16 weeks
Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**